The CHILDREN'S HEALTH PLACE

Consent to Treat Minor Children

Patient's Name: _____

Patient DOB: _____

I, _____, parent or legal guardian do hereby consent to any medical care and the administration of medications and vaccines determined by a physician to be necessary for the welfare of my child while under the care of the following individuals:

Please list yourself, additional parents, family members, and friends of family who may bring your child to appointments. Siblings of patients must be 18 years or older in order to bring the patient to an appointment.

Print Name	**Relationship to child**

Effective Date: _____

Signature of Parent or Legal Guardian: _____

Print Name: _____